## **EXHIBIT A**

### EARNEST SHIELDS v. ILLINOIS DEPARTMENT OF CORRECTIONS, et al. 2010-cv-3746

#### Medical Records

- 1) Illinois Department of Corrections Medical Records (1-54)
- 2) Dr. David Olysav, Southern Illinois University-School of Medicine (55-64)
- 3) Dr. Benjamin A. Goldberg, University of Illinois Medical Center at Chicago (65-66)
- 4) Galesburg Orthopedic Services (67-78)
- 5) Galesburg Cottage Hospital (79-112)
- 6) Dr. Gregory A. Schierer, M.D., Galesburg Orthopedic Services (113-115)
- 7) Cottage Rehabilitation & Sports Medicine (116-133)

#### Medical Bills

- 8) University of Illinois Medical Center at Chicago (1)
- 9) Galesburg Cottage Hospital (2)
- 10) Cottage Rehabilitation & Sports Medicine (3)

FILE COPY

#### Offender Injury Report

A STATE OF THE STA	
Offender Name: Shu 200 Ernsit 10# R6L	,\(,\)
Age: 34 Date of Birth: \$19171 Sex: 70 Race: B)X	
Date of Injury: 6/16/08 Time of Injury: 1315 Dam Dom Location:	
How did the injury occur?	
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	terre transcription to the second
	# # T
Was it witnessed by static No. ☐ Yes (If yes, please list names)	
Location in facility: Type of injury:	
☐ LTA (gym, basketball, football, etc.) ☐ Sports	
☐ Group (therapy) ☐ Assault	•
☐ Housing Unit (cell, dayroom, tv room, etc.) ☐ Job Related	
☐ School (classroom, library) ☐ Non-job Related	
☐ Kitchen ☐ Self-Inflicted	
₹Other □ Fight	•

(Medical Report on Reverse Side)

Offender Name: Shield Convos	10# R66161
Date of medical examination: 6/16/08 Time: 1320	✓ pm Physician Contacted:    ✓ Yes
S (Subjective Findings): Im her with lettings)	220 5 7 7
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O (Objective Findings):	•
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P (Treatment and Follow-up): D x 1/2 X 20000	Dentico VI Draighoum
P (Treatment and Follow-up): 1 200	
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Off-site referral for treatment (Destination)	Infirmary Segregation
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Print Name of Person Completing Form	Signature
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To Be Completed By Physician	
ve reviewed this report and would like to see this offender.   Immediately	☐ Next Sick Call ☐ PRN
	ANA 1 Print Avenue Avenue
201	
ALEALORUM EMPHOSician Name Physician's Signature	6/16/12

FAX COMPLETED FORM TO: (412) 937-9151

#### WEXFORD HEALTH SOURCES, INC.

#### EMERGENCY / HOSPITALIZATION NOTIFICATION FORM

CORRECTIONAL FACILITY	: Will Co.		4
DATE	= 6/16/08	REFERENCE NUMBER:	B69191
INMATE NAME	Shirl Cornel	SEN:	
INMATE NUMBER	M / /	BOD	2-19-71
ADVANCE DIRECTIVES	S YES NO		
REFERRING PHYSICIAN	٧ .		
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	STAT LAB	URGENT OFFICE	URGENT RADIOLOGY/X-RAY
	OTHER	i.	
FACILITY/PLACE OF SERVICE	Cathana !	Wasptal	
ADDRESS:	: Dolook	200 6401	(
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TELEPHONE:	343-8131	gamman and an and an	and the state of t
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DATE DUT	6/16/08	TIME:	1415
REŢUŖN DATE:		TIME	
ADMISSION DATE:		, TIME:	A CONTRACTOR OF THE CONTRACTOR
TRANSMITTAL DATE:	· Page Page Page Page Page Page Page Page	TIME:	
BY:	- And the second	Manager of the second s	
AFTER HOURS NOTIFIED	YES NO		
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SML

#### ILLINOIS HEDICAL DIRECTOR OA EMERGENCY REPORTING FORM FACILITY: PHYSICIAN NAME: PHYSICIAN SIGNATURE: DUCH TIME OF EMERGENCY EVENT TIME OF DAY: Medical History: Current Medications: Psych History (if applicable) Yes 12 No. s) When was the patient lest seen by Mental Health b) Is the patient compliant with higher psychotropic medications: Emergency Medical History Emergency Physical Findings (pertinent PE and Lab findings): PROVISION OF ONSITE EMERGENCY MEGICAL CARE If the emergency occurred after hours, was the on-call physician notified? ) Name of on-call physician? What emergency medical care was rendered? Did the patient respond to emergency treatment? Why was the patient transferred to the ER? is this medical condition a result of: Sports Injury Result of an altercation DISPOSITION Name of ER physician spoken to: Was the patient returned to the facility? 3) Was the patient admitted to the hospital? What services necessitated hospital admission? Type of Transportation \_\_\_\_ Ambulance \_\_\_\_ State Vehicle Air Ambulance Other

This form must be submitted to Dr. Funk no later than 12 Noon EST on the next working day Fax: 312-948-3622

ER Referral; Yes

Was referral preventable? Yes

Appropriateness (Completed by Wexford UM Physician):

Wumber: 5290082

Name : SHIBLDS WARNEST D

Rm/Bed: O/P / MOP Admit : 6/18/08

DX I SHOULDER ENJURY

Sx/Rca: M-B

PECIE

DOB : 2/19/71

LOG : 37 HE/WELL

Charge 416BP4 Ordering Dot: RAD

Order Dr/7m / 6/16/08 17:04

Order Status; ROUTINE

Diant DE/10 1 6/16/08 17:04 Keyed By CETHODOPE

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COMPLETE MR SAYETT FORM

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B/C7 EE

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HEP

200 MR-UPPER EXTREMITY

ISOLATION NONE

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#### Hill Correctional Center

#### Offender Outpatient Progress Notes

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vution: Offender's Medical Record

DOC 0084 (Eff. 9/2002) (Replaces DC 7147)

### Hill Correctional Center

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Hill Correctional Center .

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### HIII Correctional Center.

### Offender Outpatient Progress Notes

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### Hill Correctional Center

### Offender Outpatient Progress Notes

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Distribution: Offender, Offender's Medical File, and

Print Facility Medical Director's Name

OneRadiology

Normal, Illinois 61761

June 24, 2008

Patient Name: Shields, Ernest

Patient No# 866161

DOB: 2/19/71

Dr. Migliorina

Hill Correctional Center

LEFT SHOULDER TWO VIEWS 6/16/08

INDICATION: Pain,

FINDINGS: The views of left shoulder show no bony or soft tissue abnormality.

IMPRESSION: Normal left shoulder.

CHEST ONE VIEW 6/16/08

INDICATION: Pain.

FINDINGS: Lungs are clear. Heart is normal. Bony thorax is unremarkable.

IMPRESSION: Normal chest.

Signed

CL:eg

DIC: 6/24/08 Films from Hill Correctional Center

TIME REC INITIAL DATE

### Hill Correctional Center ...

### Offender Outpatient Progress Notes

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### Hill Correctional Center ·

### Offender Outpatient Progress Notes

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### Hill Correctional Cenfer.

### Offender Outpatient Progress Notes

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### Hill Correctional Center ... :

### Offender Outpatient Progress Notes

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### Hill Correctional Center.

### Offender Outpatient Progress Notes

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2-18-08 DENIAL NOTE PRICED award	
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### Hill Correctional Center

### Offender Outpatient Prógress Notes

	Offender information:
	Last Name Courest ID# Shelled
Date/Tlme	Subjective, Objective, Assessment
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10:3600	Peter Ototho and De Clark needed
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Date: 8 / 8 / 08	Patient Information:		**
Time: 8:30 Pa.m.	Swells Last Name	<u>Earnest</u>	ID#:1366/6/
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The nature and extent of the intended t	freatment has been explained to	man for affects 11 for the second	
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l acknowledge that no guarantee or ass	urance has been made as to the	results that may be obtained.	•
Loorlife that I have read and to the condens			
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Ernest Sholds	V Exerce Sh	tul)	erleded
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RUTH A BROWNEW Park Name of Witness	Katta yu B	LOWERN 8,	8 108 19

Mercara Mine. Sheles, Eurast 1 1866/6/ ] Hon-Formulary Riscipalions [] Madical Equipment Consult Reason for Referral: Management Procedura/service (specify) \_\_ 1. Cloub / Pepis outhpelle Center 10 Outh End ( Pectous Par) U+rgenit: ☐ Yes Date Referring Practitioner's Signature Report of Referral (Use Reverse Side, if necessary) Print Referring Practitioner's Kame . indings: Assessment: .Recommendations/Plan D.V Pracillioner's Signature Clarke Print Practitioner's Name Facility Medical Director Use Only I have reviewed the recommendations and: Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, Approve. 9/11/118 Data L DOC 0255. Facility Modizal Directo Y.I. 6 L12 AM Print Facility Medical Director's

### Hill Correctional Genter

### Offender Outpatient Progress Notes

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## ILLINOIS DEPARTMENT OF CORRECTIONS Hill Correctional Center...

### Offender Outpatient Progress Notes

Offender Information:

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# ILLINOIS DEPARTMENT OF CORRECTIONS Hill Correctional Center.....

### Offender Outpatient Progress Notes

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de continu
Offender's Name: Steldo, Earnest 10# B66161
Reason for Referral: Consult Non-Formulary Medications Medical Equipment  Evaluation Management  Procedure/service (specify)  Other (specify)
Urgent: Yes No
Preferred to: Oh. Olypan 15 IV Letterles Terror Rupture)  Rationale for Rieferral: Oths. Eval. (Pectabelles Terror Rupture)
Rationale for Referral:
Report of Referral (Use Reverse Side, if necessary)
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Recommendations/Plans: P. T. E Shrulllur
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Print Practitioner's Name Practitioner's Signature Date
Facility Medical Director Use Only
I have reviewed the recommendations and:
Approve.
Deny or revise as Indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.
R.MO, LOS RIMIBLIORINO 8/24/08
Print Facility Medical Director's Name Facility Medical Director's Signature Date
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11.

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Administrative Review Beard, only if the issue involves to administration of psychologologicular, issues from ariginar is	note deptal by the Transfer Coordinator, protective custody, involuntary colling except personal property issues, or issues not resolved by the Ohlef
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Offender's Signature	3 B66/61 8127 108
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· · · · · · · · · · · · · · · · · · ·	Response (If applicable)
Date Received: 1,2,00 × Send directly to G	Administrative Review Board, P.C. Box 19277.
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Print Counselor's Name	Counselor's Signature Date of Responses
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	of an emergency nature? Yes; expedite emergency grievance    No an emergency is not substantiated.
	Offender should stibmit this grisvance by the normal manner:

#### Hill Correctional Center

#### Offender Outpatient Progress Notes

Offender Information:		And the second s
Sheleb Last Name	First Name MI	110#: BGG/GX

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Offender Information:

#### TLLINOIS DEPARTMENT OF CORRECTIONS

### Hill Correctional Center

### Offender Outpatient Progress Notes

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## STATE OF ILLINOIS - DEPARTMENT OF CORRECTIONS

### MEDICAL PROGRESS NOTES

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Inmate's Name	Jell	Immotale Attenut . Q//	11 E
		Inmate's Number 1366	61

Treatment Protocol - Fractures, Dislocations, an	d Sprains
Date/Time SOA	PLANS
130/54 S. When did injury occur? July	P. M.D. referral:
1230 How did it happen? with	(any deformity, severe pain on arrelli-
Form ( ) twhen to be south	discoloration, limited motion, cool to touch,  pulses diminished or absent)
Did it swell immediately? (Y. N	G. \$2 copay implemented due to inmate's request
Pain N N	for non-emergency medical services.
If yes, describe (1-10 most severe):	No. M.D. referral (check as applicable):
Any previous injury to same site? Y(N)	1. Cold applications 15-20 min. Q 2 hrs x 48 hrs then heat x 72 hrs.
	2. Tylonol 325 mg 2-3 tabs OR Ibuprofen 200 mg Q 4 hrs PRN x 3 days for pain and swelling.
Did patient walk to unit? Y N	
0. TGG PCO R [6 BP 1400 " 4	2. Splint and elevate extremity. 1. If not necessary to retain in infirmary, have
Deformity: Y	patient return to murse screening in 48 hrs.  for re-evaluation.
Alteration in ROM? Cull col Y N	LOT 10-18 HINES-01 FOR
Swelling	affect teaching (short
f 13100010mmin	Medications usage.
Numbrane	and hot application. Used
	No weight bearing and keep area immobilized
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Check pertinent pulseer, on a dia	rufeh er cane walking.
ARRIE: OTTAWA = (5) I	if injury preventable, safety measures to prevent ecurrence.
1 1/2 2000 - march in 1/2	The sales
Knee: OTTAWA	um PRN if pain not relieved by analgesic,
	Hing increases, and/or numbness develops.
when Rolling should be !	nplete Resident Injury Report Form
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### Hill Correctional Center -

### Offender Outpatient Progréss Notes

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ulium (marting artical marting).
Offender's Name: Shills, Earnest 10# BG4/61.
Reason for Referral: Consult Non-Formulary Medications Medical Equipment  Evaluation Management  Procedure/service (specify)  Urgent: Yes No  Referred to: Cottag. Dellat PT
Referred to: Cottag Feld for PT for Left Pertuil Tean Rationals for Fleterral: I would for PT for Left Pertuil Tean
Print Referring Practitioner's Name . Referring Practitioner's Signature . Date
Findings: Army and deformity of sex muscle (a) weakness (to.  pain, limited APPROM (D) Shoulden a quality noted of original value per deformity.
Assessment: At above pain; weakness, limited now limited.
Recommendations/Plans: Cent PT is the MD order x 2 mine ruits to address reconcelled and nOM 94700 The A voices concern nes need (nuigical Intervention and nes the overall langles)
Jason Grandonie Acaditioner's Signature Date Date
acility Medical Director Use Only
have reviewed the recommendations and:
Approve.
Deny or revise as Indicated on the Norfication of Medical Service Referral Denial or Revision,  DOC 0255.  H LOCHARDMD  Facility Medical Director Signature  Date

Hill Correctional Center...

### Offender Outpatient Progress Notes

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### Offender Outpatient Progress Notes

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### Hill Correctional Center . . .

### Offender Outpatient Progress Notes

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### ILLINOIS DEPARTMENT OF CORRECTIONS RESPONSE TO OFFENDER'S GRIEVANCE

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•	• •	Grievance	Officer's Report			
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Date Received: October	20, 2008	Date of Review	w: October 21, 2008		Grievance # (optor	ult: 090541
Offenden Shields					ID#: <u>B66161</u>	
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Osel Administratives	March Elevelum				Date	<u> </u>
•	, Off	ender's Appeal T	To The Director			

I am appealing the Chief Administrative Officer's decision to the Director. I understand this appeal must be submitted within 30 days after the date of the Chief Administrative Officer's decision to the Administrative Review Board, P.O. Box 19277, Springfield, IL 52794-9277. (Attach a complete copy of the original grisvance, including the counselor's response, if applicable, chid any pertinent documents.)

MEY 25. 2019 1:54PM SML NACIONE DEPARTMENT OF CORRECTIONS  Offender Health Status Transfer Summary  Defender Defender Summary  Defender Health Status Transfer Summary  Defender Health Status Transfer Summary  Defender Transfer Summary  Defender Health Status Transfer Summary  Defender Transfer Summary  Defender Health Status Transfer Summary  Defender Health Stat		Offender Health Status Transfer Summary	211
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Other (specify):  Printed Name and Title  Signature  Date	Print Name and Title  Print Name and Title  Print Name and Title  Exprison Screening (completed by receiving facility heat  Facility:  Print Name and Title  Print Name and Titl	Plan: Disposition:    Health Information Given   Emergency Referrate   Chronic   Medication Evaluation   Thorspentic Dist   Special Housing   Chronic   Work / Program Limitation   Specialty Referrate   Chronic   Chro	A.m.
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ognaure Date	Antal Health Isaues:	Plan: Disposition:    Health Information Given   Emergency Referral:   Sick Call: Urgent / Routine   Special Housing   Chronic   Work / Program Limitation   Specialty Referrals   Other (apocity):   Infirmery Placement:	A.m.
ognature Date	Print Name and Title  Print Name and Title  Print Name and Title  Deption Screening (completed by receiving facility heat  active:  Durrent Medications/Treatment:  Scrive:  Hysical Appearance/Behavior:  Seformities: Acute/Chronic;	Plan: Disposition:    Health Information Given   Emergency Referral:   Sick Call: Urgent / Routine   Special Housing   Chronic   Work / Program Limitation   Specialty Referrals   Other (apocity):   Infirmery Placement:	A.m.
ognature Date	Print Name and Trive  Print Name and Trive  Deption Screening (completed by receiving facility heateristics:  Current Complaint:  Purrent Medications/Treatment:  Sociiva:  Inysical Appearance/Behavior:	Plan: Disposition:    Health Information Given   Emergency Referral:   Sick Call: Urgent / Routine   Special Housing   Chronic   Work / Program Limitation   Specialty Referrals   Other (apocity):   Infirmery Placement:	A.m.
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duit Transition Canter transfers only:	Print Name and Title  Print Name and Title  Ception Screening (completed by receiving facility heat  Facility:  Durrent Complaint:  Current Medications/Treatment:  Scrive:  Print Name and Title  Pri	Plan: Disposition:    Health Information Given   Emergency Referral:     Sick Call: Urgent / Routine   Modication Evaluation   Therapeuric Diet   Special Housing   Chronic   Work / Program Limitation   Specialty Referrals   Other (specify):     Infirmatry Placement:   HiV Test & Counseting Offered (anity transfers from REC).	A.m.
Island that medical and dental care are my responsibility while I am harved in	Printed Name and Title  Printed Name and Title  Printed Name and Title  Printed Name and Title	Plan: Disposition:    Health Information Given   Emergency Referral:     Sick Call: Urgent / Routine   Modication Evaluation   Therapeuric Diet   Special Housing   Chronic   Work / Program Limitation   Specialty Referrals   Other (specify):     Infirmatry Placement:   HiV Test & Counseting Offered (anity transfers from REC).	A.m.
The state of the s	Printed Name and Title  Adult Transition Center transfers only:  Instant that medical and denial care are my rector	Assessment:	Druge A.m. P.m.
months, months, months, months, al donial needs.	Printed Name and Title  Adult Transition Center transfers only:  Instant that medical and demandance are pre-my restored.	Assessment:	A,m, p,m.



765 North Kellogg Street Galesburg IL 61401 Phone: (309) 343-3434 Fax: (309) 343-3456

### PHYSICAL THERAPY INITIAL EVALUATION

Name:	Eurest Sh	relds		Physician:	On M	19/00/NO	•	
Diagnosis:	tear of (	Padonalis		Onset Date:		6/08		
D.O.B.:	2/19/19					ed IB	. ,	<del></del>
Physician Ord		Ealand T	cet x 3	visit	4			
SUBJECTIVE	INFORMATION	<u>l</u>						
History: M	ledical: <u>U</u>	oother i	PMH no	tel.				,
87.) <b>P</b> i	revious Functiona	Level: and	function	nal le	relpse	o injury	/	Politication
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whilea	tamptino	to benef	365# He/	all the	+ Alexander	an is ris	+ canot	holes
Vocational Cor	nsidenations:	and here	els my	w	7	7		7
Current Compl	aints: Asia	to chart	2 rembras	Osido	globes	9-16 este	w aun	forom
Functional Lim	Itations: ozen	lead, we	homes of AD	US. LL	in act a	ight	P	remand
Pain Level (0-1	0 Scale):	plio Wor	st		n: Da	O. Fr.		*
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Test Results:	Pain dis	Itxray	( lie and	chia see	~ 1 1			
Patient Goals:	The Aug.	ate surgery	to live to	to	man of On	1/1	1-1-	10 1.00
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	Am. 1							•
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PROM: 62	Meun (b) 1	100 quarking &	WARDQ10	Dogwating	SKIKO	TO SAE	(@ 860	
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Sensation:		Du osses			10			
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No. 2943 P. 453
/bo-North-Kellogg-StreetGalesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

## **Ecottage**

### PHYSICAL THERAPY INITIAL EVALUATION (CONTINUED)

Name: Eun	rest Shields			
Assessment:		<i>a</i> –		
35 y.o.	67 à diagnon	ed of ( Pa	ctaralist	as demonstrat
an obvio	us deformity	in the Do	ar musch	E sain/abilel
tenden	assagnotely,	limited Plu	mon Jid	
I'd fine	The detricty	therene	The stru	all benefit from
man al		sits per mo	order to a	deliers the dose
west diffe	ut and arow &	fated goals	ikts	
TREATMENT PLAN			•	
Goals:			•	
STG: 1-2	real	LTG:	3 4	
10 EHE	Pasapaguiato.	1.6	amo L= R 8.	haller story
		that ale	me. 24/8 2	tingth Open
usia			Q = 4/5 Sh	
	to create the second se	3, /	emonstrate	functional movement
			Tho(a)	
Rehab Potential:	☐ Excellent		= 3/10 (C) ch	11 '
Two was a ma Austria.	LA LAURINIE	□ Good )	Fair (For D	<b>700</b> F
Treatment Orders:	Therex, MI	Rodelal	in Price	
Today's Treatment:	157 - 1. 1.	Sur 1 On Pl	100 51	0-11
1 HEP inel	per 10/9/08 His	E july ju	, 130, ES	onderse to toulon
	10-17-01 1100	, e page	mones	
Experience of the second secon	· ·			The state of the s
Procedure/Mins:	TEX17			Total Treatment Mins: 17
Transment Empressed	1.1.	1	A description	
Treatment Frequency:	1x levely d	buceds Expec	ted Duration:	Strict (Queeks)
Certification Period (Med	1	- 10		The state of the s
Discharge Plan:	han you goals.	are met		£
Therapist's Signature:	fronthands	1 MS PT	Date:	10/9/08
- Medicare recipients	require signature of physician	n. Non-Medicare recip	piants require print o	f physician's name.
Physician:	•	• • •	Date:	· · · · · · · · · · · · · · · · · · ·
	·		### NEW PROPERTY N	